

# MEDI-CAL MANUAL

for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members



CDSS

CALIFORNIA  
DEPARTMENT OF  
SOCIAL SERVICES



California Department of  
**HealthCareServices**



If you have questions regarding obtaining ICC, IHBS or TFC for a child that meets the Katie A. Subclass criteria described in Chapter 2 of this Manual, please contact your County Mental Health Plan (MHP). A list of County MHP's toll free numbers can be located at

<http://www.dhcs.ca.gov/services/MH/Documents/CMHDA.pdf>

or contact the Beneficiary Services Unit at the Department of Health Care Services at 1-800-896-4042.

## State of California



TOBY DOUGLAS  
*Director*



EDMUND G. BROWN JR.



CDSS  
WILL LIGHTBOURNE  
DIRECTOR

Greetings Colleagues:

We are pleased to provide the “Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) for Katie A. Subclass Members.”

We developed this manual with Mental Health Plans (MHPs) and Medi-Cal Specialty Mental Health Services providers in mind to help provide these intensive services to children/youth who are members of the Katie A. Subclass and their families. These are children and youth who have the most significant needs, and by receiving ICC and IHBS in their own home, family setting or the most homelike setting, will be most likely to greatly improve their safety, permanence and well-being.

This manual provides guidelines for delivering and billing ICC, IHBS and at a later date, TFC services and is a companion document to the Core Practice Model (CPM) Guide, which describes a shift in how individual service providers and systems are expected to address the needs of children/youth and families in the child welfare system.

It is our hope that the use of these two documents will help transform the way mental health and child welfare administrators and providers work together to assist and support children/youth to achieve and maintain the highest possible level of health, well-being and self-sufficiency.

This manual is a living document, and it is the first step in providing standards and guidelines for the delivery of ICC and IHBS. We anticipate that we will augment, refine and revise the manual as MHPs and providers start delivering services. The Department of Health Care Services and the California Department of Social Services will be working with stakeholders to develop additional training materials to further promote and support the delivery of these intensive services across the state.

Going forward, we will continue to work with our partners towards transforming and improving the mental health delivery system for Katie A. Subclass members and all children served through these systems in California.

Sincerely,

Toby Douglas, Director  
Department of Health Care Services

Will Lightbourne, Director  
California Department of Social Services

# TABLE OF CONTENTS

<b>CHAPTER 1: PURPOSE AND BACKGROUND</b>	<b>1</b>
• Purpose	1
• Background	2
<b>CHAPTER 2: ELIGIBLE POPULATION: KATIE A. SUBCLASS CRITERIA</b>	<b>3</b>
<b>CHAPTER 3: THE CORE PRACTICE MODEL (CPM)</b>	<b>4</b>
<b>CHAPTER 4: THE CHILD AND FAMILY TEAM (CFT)</b>	<b>5</b>
• Elements of Successful Teaming	5
<b>CHAPTER 5: ICC, IHBS AND TFC</b>	<b>7</b>
• Planning for ICC, IHBS and TFC	7
• INTENSIVE CARE COORDINATION (ICC)	7
• General Description	7
• Service Settings	8
• Claiming and Reimbursement	8
• ICC Service Components/Activities/Documentation	8
• Service Components/Activities	9
■ Assessing	9
■ Service Planning and Implementation	10
■ Monitoring and Adapting	10
■ Transitioning	10
• Documentation of Service Components and Activities	11
• Points on Claiming for Multiple Staff	12
• INTENSIVE HOME BASED SERVICES (IHBS)	12
• General Description	12
• Service Settings	13
• Claiming and Reimbursement	14
• Coordination of IHBS with other Mental Health Services	14
• THERAPEUTIC FOSTER CARE (TFC)	15



<b>APPENDICES</b> .....	16
• Appendix A – Glossary .....	16
• Appendix B – Core Practice Model .....	19
• Appendix C – The Child and Family Team (CFT) .....	21
• Appendix D – ICC, IHBS & TFC Service Reference Chart.....	22
• Appendix E – Sample Progress Notes .....	29
• Appendix F – Medical Necessity Criteria.....	31
• Appendix G – Providers Eligible to Deliver ICC and IHBS .....	34
• Appendix H – Non-reimbursable Activities .....	36
• Appendix I – Katie A. Settlement Background .....	37
 <b>ACKNOWLEDGMENTS</b> .....	 38



# CHAPTER 1: PURPOSE AND BACKGROUND

## PURPOSE

The purpose of this manual is to provide mental health plans (MHPs) and Medi-Cal providers with information concerning the provision of three covered specialty mental health services for those children/youth who are members of a class of children covered by a [Settlement Agreement](#) in a lawsuit *Katie A. v. Bonta* (hereafter “the Katie A Subclass”).

This manual is only applicable to Intensive Care Coordination (ICC); Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) and the new Core Practice Model (CPM). The CPM is defined in Appendix B and in Chapter 3 and further articulated in more detail in a companion document called the *Core Practice Model Guide* that should be relied on for further guidance on the expectations of the model and the required elements for fidelity practice to the model. The CPM describes a significant shift in the way that individual service providers and systems are expected to address the needs of children/youth and families in the child welfare system, and additionally, it is intended as a blueprint for wider practice change and systems reform. TFC is currently being developed as part of the Katie A. Settlement and specific information about TFC will be added in an addendum to this manual at a later date.<sup>1</sup>

This manual sets forth the standards and guidelines for the delivery and billing of ICC, IHBS and TFC. It also serves as a supplement to other federal and state documents related to the delivery of specialty mental health services in the State of California including, but not limited to:

- Federal Medicaid [laws](#) and [regulations](#)
- [California Code of Regulations \(CCR\), Title 9, Division 1, Chapter 11](#)
- California Medicaid State Plan
  - [Targeted Case Management](#)
  - [Rehabilitative Mental Health Services](#)
- [California Department of Health Care Services \(DHCS\) contract with the MHPs](#)
- DHCS/CDSS Core Practice Model Guide
- DHCS All-County Letters, former [Department of Mental Health Policy Letters](#) and [Department of Mental Health Information Notices](#)

This manual will be maintained by DHCS and reviewed and updated as needed. The most recent version of this manual can be found on the [DHCS Katie A Settlement webpage](#). Any questions concerning the standards and guidelines set forth in this manual should be directed to: [KatieA@dhcs.ca.gov](mailto:KatieA@dhcs.ca.gov).

Please note that MHPs and providers should continue to provide existing effective specialty mental health services, when medically necessary, to children/youth who are not Subclass members. ICC and IHBS provided to Subclass members should be identified using the new procedure codes listed in this manual (see pages 8 and 14) and ICC and IHBS should be provided based on the medical necessity for intensive intervention.

---

<sup>1</sup> TFC is currently being developed and specific information about TFC will be added in an addendum to this manual at a later date.

## BACKGROUND

As a result of the [Settlement Agreement](#) in *Katie A. v. Bonta*, the State of California has agreed to take a series of actions that are intended to transform the way California children/youth who are in foster care, or who are at imminent risk of foster care placement,<sup>2</sup> receive access to mental health services, including assessment and individualized treatment, consistent with what has been defined as a Core Practice Model or CPM that creates a coherent and all-inclusive approach to service planning and delivery. The Settlement Agreement objectives are to:

- (a) Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach;
- (b) Support the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described in (a);
- (c) Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;
- (d) Address the need for certain class members with more intensive needs (hereinafter referred to as “Subclass members”) to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification, and to meet their needs for safety, permanence, and well-being.

To expedite implementation of the Settlement

Agreement, a Subclass of these children/youth who have the most intensive and complex needs (Katie A. Subclass), has been designated to be provided a more intensive array of mental health services that:

- Are delivered in a well-coordinated, comprehensive, community-based fashion;
- Are consistent with the Core Practice Model principles and components, including:
  - a strong engagement with and participation of the child/youth and family;
  - focus on the identification of child/youth and family needs and strengths when assessing and planning services;
  - teaming across formal and informal support systems;
  - use of child/youth and family teams (See definition in Appendix A, Glossary and in this manual on pages 5-6) to identify strengths and needs, make plans and track progress, and
  - provision of intensive home-based rehabilitation services;
- Assist, support and encourage each eligible child/youth to achieve and maintain the highest possible level of health, well-being and self-sufficiency;
- Reduce timelines to permanency and lengths of stay within the child welfare system; and
- Reduce reliance on congregate care.

For additional background information, please refer to Appendix I.

---

<sup>2</sup> As defined in the Settlement Agreement.

# CHAPTER 2: ELIGIBLE POPULATION:

## KATIE A. SUBCLASS CRITERIA

As set forth in the Settlement Agreement: *These are children and youth who have more intensive needs to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification and to meet their needs for safety, permanence and well-being.* Children/youth (up to age 21) are considered to be a member of the Katie A. Subclass if they meet the following criteria:

- Are full-scope Medi-Cal (Title XIX) eligible;
- Have an open child welfare services case (See definition in Appendix A, Glossary); and
- Meet the medical necessity criteria for Specialty Mental Health Services (SMHS) as set forth in CCR, Title 9, Section 1830.205 or Section 1830.210.

In addition to:

- Currently in or being considered for: wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive EPSDT services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention (see definitions listed in glossary); or
- Currently in or being considered for group home (RCL 10 or above), a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs.

In coordination with county child welfare agencies, MHPs have the responsibility for establishing an eligibility determination process for the Katie A.

Subclass. MHPs have the flexibility to create an eligibility determination process that works for their county to reduce any potential delays or barriers to access to services. The eligibility determination process must be documented and include language that establishes that the child/youth meets the Katie A. Subclass criteria noted above.





# CHAPTER 3: THE CORE PRACTICE MODEL (CPM)

The Core Practice Model (CPM) is a set of practices and principles for children/youth served by both the child welfare and the mental health system that promotes a set of values, principles, and practices that is meant to be shared by all who seek to support children/youth and families involved in the child welfare system, including, but not limited to education, probation, drug and alcohol and other health and human services agencies or legal systems with which the child/youth is involved.

**The implementation of a CPM should be used to guide the delivery of integrated and coordinated child welfare and behavioral healthcare services.**

The framework of the CPM is a shared set of practice principles to be used when providing services to members of the Katie A. class, including members of the Katie A. Subclass. As previously noted, the CPM is defined in Appendix B and further articulated in more detail in a companion document called the *Core Practice Model Guide*.

In brief, the CPM provides a prescribed set of family-centered practice values and principles that drive a definable planning and service delivery process. The CPM values and principles are summarized as follows:

- Children/youth are first and foremost protected from abuse and neglect and maintained safely in their own homes.
- Services allow children/youth to achieve stability and permanence in their home and community-based living situations.
- Services are needs-driven, strengths-based, and family-focused from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child/youth and their family.
- Services are delivered with multi-agency collaboration that is grounded in a strong, shared preference for community-based services and resources, and reflected in alignment of all service plans.
- Family voice, choice, and preference are assured throughout the process and can be seen in the development of formal plans and intervention strategies where the child/youth and family have participated in the design.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions beyond system services that ensure long-term success.
- Services are respectful of and informed by the culture of the children/youth and their families.
- Services and supports are provided in the child or youth and family's local community and in the least restrictive and most normative settings.

# CHAPTER 4: THE CHILD AND FAMILY TEAM

While the Katie A. Settlement Agreement only stipulates a formal and prescribed Child and Family Team (CFT)<sup>3</sup> for Subclass members, the CPM incorporates the practice of teaming for all youth and families. The CFT is central to the CPM. The CFT is comprised of the youth and family and all of the ancillary individuals who are working with them toward their successful transition out of the child welfare system. The team process begins with the initial interactions between the child welfare worker and the youth and family, a small informal team working together to identify the youth and family's strengths and underlying needs. As these strengths and needs are identified, the original team expands to include other members as necessary and appropriate.

What is transformative for the child welfare and mental health systems is the recognition that it takes a team of people working together using the CPM approach to achieve safety, permanency and improve well-being. Child welfare workers and mental health staff and service providers need to become knowledgeable about and comfortable working within a team environment which engages youth and families as partners. This is a skill that will take time to acquire and will require training and coaching. Each individual team member has

their unique role and responsibilities, but they are always working as part of the team. The CFT process is encouraged for every child/youth and family receiving services through child welfare and mental health as a best practice, as all children/youth can benefit from some kind of child and family team.

## ELEMENTS OF SUCCESSFUL TEAMING

Teaming has been a traditional practice in social work, child welfare, and mental health. This process of integrating the varying perspectives of individuals with diverse educational, professional and personal life experiences guards against individual bias, while promoting better informed decision making and transmission of learning. In California over the past two decades, teaming efforts in child welfare services have merged professional multidisciplinary teams with the family and youth involvement which has effectively advanced and transformed systems of care. Several teaming models commonly used in child welfare, such as [Team Decision Making \(TDM\)](#) and [Family Group Decision Making \(FGDM\)](#), emphasize the importance of family presence and participation.

**The CFT is a team that shares a vision with the family and is working to advance that vision, while a team meeting is how the members communicate. No single individual, agency or service provider works independently. Working as part of a team involves a different way of decision-making.**

---

<sup>3</sup> The CFT is defined in the Settlement Agreement and in Appendix C of this manual.

The teaming process is most successful when:

- Team membership includes the child/youth and family; extended family; informal support persons such as friends, coaches, faith-based connections; formal supports such as mental health, child welfare and educational professionals; and representatives from other agencies providing services to the child/youth and family. These may include, but are not limited to: regional center case managers, probation officers, substance use disorder specialists and health care professionals.
- Team composition is guided by the family's input and their needs and preferences.
- Team meeting schedules and locations are guided by the family's needs and preferences.
- All team members participate in the development and implementation of the care plan and are responsible for supporting the child/youth and family in attaining their goals.
- The process is standardized to include:
  - A clearly defined purpose, goal and agenda for each meeting;
  - An agreed-upon decision-making process;
  - Identification of family strengths and needs;
  - A brainstorming and option-generating process; and
  - Specific action steps to be carried out by team members according to a timeline.

The CFT for Katie A. Subclass members is comprised of individuals committed to work with and support the child/youth and family to meet their needs and achieve their goals. In addition to the child/youth and their family, the CFT includes the various agency and provider staff involved in service delivery to the family, as well as people who are natural (non-paid) support persons including relatives, friends or other community resources. The principle role of the CFT is as follows:

- Identification of important persons to participate on the CFT;
- Identification of the needs and strengths of the child/youth and their family, those of other CFT members, and other potential resources to support child/youth and family success;
- Articulation of the goals of the child/youth and family, as well as those of the system partners, so that the efforts of the team in planning and service delivery are in alignment with a shared goal of child safety, permanence, and well-being;
- Development of a shared plan(s) to address risks and meet the needs of the child/youth and their family in a way that builds on strengths and natural supports in addition to the use of formal system resources;
- Routine evaluation and refinement of plan intervention strategies to assure that progress is made toward the established goals and changes are made if approaches are not successful; and
- Planning for the transition of formal services as goals are met and symptoms and problem behaviors are improved and result in improved developmental functioning and well-being.

This manual is not intended to address overall concerns with confidentiality and sharing of information laws and regulations. To obtain more information on these issues, please consult county policies and contracts. In addition, the CPM Guide provides additional information on information sharing processes.

# CHAPTER 5: ICC, IHBS AND TFC

**Please note that all members of the Subclass must receive ICC. In addition, Subclass members will also receive IHBS (and/or other mental health services) when medically necessary.**

This section of the Manual is intended to provide an overview of ICC, IHBS and TFC. Appendix D provides a chart with additional detail about ICC and IHBS, including who can provide these services, where these services can be delivered and how to claim for these services. TFC is currently being developed and will be added at a later date.

To create a more coherent and all-inclusive approach to the provision of care, these new definitions describe the manner in which covered mental health services are required to be delivered to the Katie A. Subclass members. These services are described below and when provided by the ICC provider(s) within the CFT and in accordance with the CPM, services are expected to be intensive, comprehensive and collaborative.

## **Planning for ICC, IHBS and TFC**

Planning within the CPM is a dynamic and interactive process that addresses the goals and objectives necessary to assure that children/youth are safe, live in permanent loving families and achieve well-being. This process is built on an expectation that the planning process and resulting plans reflect the child/youth and family's own goals and preferences and that they have access to necessary services and resources that meet their needs.

The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (child welfare, education, juvenile

probation, etc.) are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with service to the child/youth and/or family, are coordinated to support and ensure successful and enduring change.

## **INTENSIVE CARE COORDINATION (ICC)**

### **GENERAL DESCRIPTION**

**The difference between ICC and the more traditional TCM service functions is that ICC must be used to facilitate implementation of the cross-system/multi-agency collaborative services approach described in the CPM for the Katie A. Subclass.**

ICC is similar to the activities routinely provided as Targeted Case Management (TCM); ICC services must be delivered using a CFT described in the previous chapter to develop and guide the planning and service delivery process.

Although more than one mental health provider/practitioner may participate in the CFT, there must be an identified mental health ICC coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child/youth's assessment and plan addresses the



child/youth's needs and strengths in the context of the values and philosophy of the CPM.

## SERVICE SETTINGS

ICC may be provided to children/youth living and receiving services in the community (including TFC) as well as to children/youth who are currently in the hospital, group home, or other congregate or institutional placement.<sup>4</sup> When ICC is provided in a hospital, psychiatric health facility, community treatment facility, group home or psychiatric nursing facility, it may be used solely for the purpose of coordinating placement of the child/youth on discharge from those facilities and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

## CLAIMING AND REIMBURSEMENT

Refer to the [California Code of Regulations \(CCR\), Title 9, Division 1, Chapter 11](#) for applicable claiming rules.

**To clearly distinguish ICC from general TCM, ICC uses a different procedure code (T1017 HK) and service function code (07).**

ICC will be reimbursed at the same rates as Targeted Case Management Services.

In addition, the guidance for the provision of ICC in inpatient settings is subject to the same direction provided in the State Medicaid Directors Letter (SMDL) dated July 25, 2000 for TCM that states:

"For members of the target group who are transitioning to a community setting targeted case management services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions."

## ICC SERVICE COMPONENTS/ACTIVITIES/DOCUMENTATION

Engagement of the child/youth and their family is foundational to building trust and mutually beneficial relationships between the family and service providers. Engagement is a process that must be nurtured and developed throughout service delivery and is critical in allowing CFT members to work to reach agreement about services, safety, well-being (e.g., meeting critical developmental, health, education, and mental health needs), and permanency.

**While the key service components of ICC are similar to TCM, ICC differs in that it is fully integrated into the CFT process and it typically requires more frequent and active participation by the ICC coordinator to ensure that the needs of the child/youth in the Katie A. Subclass are appropriately and effectively met.**

---

<sup>4</sup> Service settings for ICC are defined in Appendix E of the Settlement Agreement.

Activities may include interventions such as:

- Facilitation of the development and maintenance of a constructive and collaborative relationship among a child/youth, his/her family or caregiver(s), other Medi-Cal SMHS providers, and other involved child-serving systems to create a CFT;
- Facilitation of a care planning and monitoring process which ensures that the plan is aligned and coordinated across the mental health and child serving systems to allow the child/youth to be served in his/her community in the least restrictive setting possible;
- Ensure services are provided that equip the parent/caregiver(s) to meet the child/youth's mental health treatment and care coordination needs, described in the child/youth's plan;
- Ensure that medically necessary mental health services included in the child/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned and/or reassessed as necessary in a way that is consistent with the full intent of the CPM;
- Provide active coordination of services and resources as required to meet the goals of the plan; and
- Provide active participation in the CFT planning and monitoring process to assure that the plan addresses or is refined to meet the mental health needs of the child/youth. Examples include:
  - Scenario #1: Clinician attends a CFT meeting and learns from the child's parent and the TBS coach that the client recently suffered a panic attack while in school. Based on this shared information, the clinician suggests the plan include practicing relaxation techniques with client to reduce levels of anxiety.
  - Scenario #2: During the CFT, Parent Partner/ Advocate learned from the parent that the child's school counselor had said the client

continues to display isolative behaviors during recess. Based on this information, the CFT coordinator or therapist works with the child's IHBS provider to encourage the child to initiate social interaction with peers during recess and strengthen his pro-social behaviors while playing such as taking turns, waiting his/her turn, listening rather than interrupting.

## SERVICE COMPONENTS/ACTIVITIES

ICC service components/activities include: assessing; service planning and implementation; monitoring and adapting; and transition. These components/activities and corresponding examples are described as follows:

### Assessing

- Assessing client's and family's needs and strengths
- Assessing the adequacy and availability of resources
- Reviewing information from family and other sources
- Evaluating effectiveness of previous interventions and activities

Example 1: CFT members, including the TBS worker, teacher, coach, parents, older sister, parent partner and youth partner, discussed the circumstances and situations where John's physically aggressive behavior takes place at school, identifying potential environmental triggers, including adults leaning too close physically to help when he is struggling with school tasks. It is noted that John is much calmer when support comes in the form of reminders about steps he can take that have been pre-planned and the adult is at least four feet away during the conversation.

Example 2: John's parents talked about the different circumstances that were going on when he became so anxious he could not handle remaining in the

location, including someone touching him or lots of noise and activity from the younger children in the house. The ICC coordinator and parent partner assisted John's parents and John to identify what circumstances were going on when he seemed calmer and more in control: morning seems better than later in the day; fewer people seem better; talking is better than touching when giving feedback.

### **Service Planning and Implementation**

- Developing a plan with specific goals, activities and objectives
- Ensuring the active participation of client and individuals involved and clarifying the roles of the individuals involved
- Identifying the interventions/course of action targeted at the client's and family's assessed needs

Example 1: The ICC coordinator, behavior specialist, John, John's parents, the child welfare worker and the teacher's aide discussed potential strengths that John can use to manage his anxiety when he is feeling stressed and frustrated by his school work that could form the basis of positive intervention strategies:

- John can tell that he is getting frustrated before he lashes out; he is able to communicate his frustration to his teacher with an agreed upon signal.
- John can read and could use a list of reminders of what to do when he's frustrated.
- The teacher's aide in the classroom recognizes that when John's leg jiggles fast, he is getting agitated. When he reminds John to breathe slowly, John does it and settles down.

All present agreed that the behavior specialist will work with the teacher's aide to develop a list of coping strategies that John can use when he is becoming agitated. The teacher's aide will track the number of times that he notices John is agitated

and how many of those times that John can use his strategies to calm down. The CFT members will evaluate at the next CFT meeting.

### **Monitoring and Adapting**

- Monitoring to ensure that identified services and activities are progressing appropriately
- Changing and redirecting actions targeted at the client's and family's assessed needs, not less than every 90 days

Example 1: Discussed Susie's level of participation and progress at the Boys and Girls (B&G) Club for the past month and what she likes about going there and what is not going as well. Susie reports that she liked the art activities, but that two girls are bullying her and calling her names so she does not want to go back. The ICC coordinator suggested strategies to increase support at the B&G Club to observe and coach Susie to respond to the girls and/or to talk to an adult. Susie agrees so the Client Plan is refined and will be reviewed in two weeks. Assignment made to behavior specialist to support Susie on Tuesday and Thursday for the next month.

### **Transition**

- Developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

Example 1: CFT participants, including the ICC coordinator, IHBS provider, Susie's parents, Susie and Susie's teacher, reviewed the client's and family's gains and progress, along with their personal strengths and external resources in order to better assist the client's transition away from formal supports. The CFT members identified the presence and effectiveness of their natural supports, which include Susie's church youth group, soccer team, and Boys' and Girls' Club leadership group, and

address ways of maximizing community resources and activities in order to ensure long-term stability for the child/youth and family.

## DOCUMENTATION OF SERVICE COMPONENTS AND ACTIVITIES

### *Active Listening during a CFT Meeting*

Example 1: Clinician attends a CFT meeting and learns from the school counselor that Sam recently grabbed the arm of another student because he was not passing the ball to the client in P.E. class. Based on this shared information, clinician will work to develop and strengthen Sam's active problem-solving skills in order to help him consider alternative solutions to anger-provoking situations.

### *Multiple staff during a CFT Meeting*

Example 2: During the CFT meeting, the client's IHBS worker learns from the ICC coordinator that Sam continues to display isolative behaviors during recess because his peers do not like how he acts (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let him play with them. The IHBS worker and ICC coordinator review with the family different interventions to apply. Based on this information and discussion, the IHBS worker will focus interventions to strengthen Sam's pro-social behaviors while playing with peers by teaching, modeling and reinforcing behaviors such as listening rather than interrupting, waiting his turn, playing more gently and appropriately, and initiating social interaction with peers. The IHBS worker and ICC coordinator each claim (to ICC) for the actual amount of time they each participated during the CFT meeting including active listening time. Each staff may claim up to the length of the meeting plus documentation and travel time. Any participation time, which may include active listening time, claimed must be supported by documentation showing what information was shared and how

it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the Client Plan).

Example 3: During the CFT meeting, the team discusses the effectiveness of various interventions intended to diminish Noah's isolative behaviors during recess at school. Noah's IHBS worker coaches Noah to talk about how he has been practicing to wait his turn, and otherwise actively listens and learns how things have been going for Noah from the perspective of his teacher and his mom. The ICC coordinator shares that when she spoke to the recess monitor, the report was that Noah goes off by himself during recess when his peers did not like how he acts (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let the client play with them. Mrs. T is upset because she feels that the school staff does not follow through with the support that they promised for Noah. The Parent Partner agrees to meet with her the following day and to help Mrs. T plan exactly what she would like the school staff to do, and how she will make that request. The IHBS worker and ICC coordinator review with the family the different interventions to apply and how they will keep track of progress. Based on this information and discussion, the IHBS worker will focus interventions to strengthen client's pro-social behaviors while playing with peers by teaching, modeling and reinforcing behaviors such as listening rather than interrupting, waiting his turn, playing more gently and appropriately, and initiating social interaction with peers.



## POINTS ON CLAIMING FOR MULTIPLE STAFF

- Refer to the [California Code of Regulations \(CCR\), Title 9, Division 1, Chapter 11](#) for applicable claiming rules.
- Each staff may claim to ICC for time at the CFT meeting clearly linked to the mental health client plan goals and/or the information gleaned during the meeting that contributed to the formulation of the mental health client plan or revisions.
- Medi-Cal reimbursement must be based on Staff time (e.g., a single staff member who participates in the CFT meeting cannot claim for more time than the length of the meeting plus any documentation and travel time).

Progress notes must include evidence of incorporation of CPM elements described in the CPM Guide. Please see Appendix E for examples of progress notes.

## INTENSIVE HOME BASED SERVICES (IHBS)

### GENERAL DESCRIPTION

IHBS are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services.

Consistent with Medi-Cal SMHS regulatory requirements and the CPM, IHBS includes, but is not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;

The difference between IHBS and more traditional outpatient Specialty Mental Health Services (SMHS) is that the service is targeted to the Katie A. Subclass (and their significant support persons) and is expected to be of significant intensity to address the intensive mental health needs of the child/youth, consistent with the plan and the CPM, and will be predominantly delivered outside an office setting and in the home, school or community.

- Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT and service plans including but not limited to the plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child/youth and/or their family or caregiver(s) about, and how to manage the child/youth's mental health disorder or symptoms;
- Support of the development, maintenance and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

## SERVICE SETTINGS

IHBS may be provided in any setting where the child/youth is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings. IHBS are available wherever and whenever needed including weekends and evenings. IHBS are typically (but not only) provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS.

IHBS may not be provided to children/youth in Group Homes. IHBS can be provided outside the Group Home setting to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits.

Example 1: IHBS worker met with Sam and his mother at their home to teach Sam behavior management skills so he can gain better self-control when upset. Explained and modeled to both mother and Sam four different self-calming techniques to use when upset.

Example 2: IHBS worker met with and observed Sam at his school during recess. Sam became upset with a peer and started banging his head on the playground climbing structure. IHBS worker prompted Sam to walk away and use one of the self-calming techniques that he has been practicing. Sam used deep breathing techniques and was able to calm himself down. IHBS worker praised him for walking away and doing the deep breathing exercises.

Example 3: IHBS worker met with Sam's mom to assist her in ways of communicating without getting so upset. IHBS worker explained to mom how her anger impacts Sam's reaction and taught her different ways of expressing herself when she is upset.

## CLAIMING AND REIMBURSEMENT

Refer to the [California Code of Regulations \(CCR\), Title 9, Division 1, Chapter 11](#) for applicable claiming rules.

**In order to distinguish IHBS from outpatient SMHS when claiming, IHBS uses a different procedure code (H2015) and modifier (HK) and service function code (57). MHS are authorized and defined in California's existing Medicaid State Plan for Medi-Cal SMHS.**

IHBS will be reimbursed at the same rates as Mental Health Services (MHS).

## COORDINATION OF IHBS WITH OTHER MENTAL HEALTH SERVICES

Children/youth who are members of the Katie A. Subclass who are receiving IHBS are eligible for all of the other medically necessary specialty mental health modes of services, consistent with their identified needs which meet medical necessity criteria. MHPs and providers should consider the full array of services and the needs of the child/youth. Certain services may be part of the child/youth's course of treatment, but may not be provided during the same hours of the day as IHBS services are being provided to the child/youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive
- Group Therapy
- [Therapeutic Behavioral Services \(TBS\)](#)



## THERAPEUTIC FOSTER CARE (TFC)

This is a placeholder for TFC. Additional information regarding TFC will be provided in an Addendum to this manual at a later date.



# APPENDIX A

## GLOSSARY

For the purposes of this manual, the following definitions are provided:

**Assessment** – means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

**CDSS** – The California Department of Social Services (CDSS) is the state agency charged with serving, aiding, and protecting needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence.

**Client Plan** – means a plan for the provision of specialty mental health services to an individual beneficiary who meets the medical necessity criteria in the California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1830.205 or 1830.210.

**Child and Family Team (CFT)** – A CFT is comprised of the youth and family and all of the ancillary individuals who are working with them toward their successful transition out of the child welfare system. The team is comprised of the child welfare worker, the youth and family, service providers and any other members as necessary and appropriate. No single individual, agency or service provider works independently but rather as part of the team for decision-making. Child welfare workers and mental health staff and service providers work within a team environment which engages youth and families as partners in that environment. Each individual team member has their unique role and

responsibilities, but they are always working as part of the team. The CFT is defined in the Katie A. settlement agreement and is described in Appendix C of this manual.

**Collateral** – means a service activity to a significant support person in a beneficiary’s life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

**Core Practice Model (CPM)** – The Core Practice Model (CPM) is a set of concepts, values, principles, and standards of practice that outline an integrated approach to working with children/youth and families involved with child welfare who have or may have mental health needs. It provides a framework for all child welfare and mental health agencies, service providers and community/tribal partners working with youth and families.

**DHCS** – The Department of Health Care Services (DHCS) is the state agency charged with preserving and improving the health status of all Californians. DHCS works closely with health care professionals, county governments and health plans to provide a health care safety net for California’s low-income and persons with disabilities.

**EPSDT** – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit for

individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need, diagnostic and treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additional medically necessary services. These additional services are known as EPSDT Supplemental Services, and include mental health-related diagnostic services and treatment (other than physical health care). These services are available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United State Code, are services that have been determined by the State Department of Health Care Services to meet the criteria of Title 22, Section 51340(e) (3) or (f); and are not otherwise covered as specialty mental health services. EPSDT services include rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication services, crisis intervention, day care intensive, and day care habilitation offered in local and mental health clinics or in the community. EPSDT services include Therapeutic Behavioral Services (TBS) for children/youth with serious emotional challenges, as well as mental health evaluations and services.

**Foster Care Placement** – 24-hour substitute care for all children placed away from their parent(s) or guardian(s) and for whom the State agency has placement and care responsibility. (Section 1355.20 Code of Federal Regulations)

**Intensive Care Coordination (ICC)** – a service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services (for children/youth who meet the Katie

A. Subclass criteria). See Appendix D for further description.

**Intensive Home Based Services (IHBS)** – are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant others and to help the child/youth develop skills and achieve the goals and objectives of the plan.

**Katie A. Lawsuit** – The Katie A. Lawsuit, *Katie A. et al. v. Bonta et al.*, refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children/youth in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011.

**Mental Health Plan (MHP)** – means an entity that enters into a contract with the Department to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

**Natural Supports** - Individuals that can further support the child and the family with developing a sustainable system of supports that is not dependent on formal systems supports. Examples are extended family members, friends, community members and others as identified by the child and family.

**Open Child Welfare Services Case** – means any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made.

**Parent Partners/Advocates** – Parent Partners/Advocates are key individuals who work with children/youth and families within the public child welfare, juvenile probation or mental health systems. Parent Partners/Advocates are past consumers and can convey information on how systems and programs can instill the family-centered and family-driven philosophy and principles necessary to engage children/youth and families.

**The plan** – A plan that comprehensively addresses and integrates the activities of all parties involved with service to the child/youth and/or family. The plan should align the goals and objectives necessary to support and ensure medically necessary services are provided to the child/youth and family.

**Plan Development** – A planning process that is a component of ICC which reflects the CPM values and principles emphasizes individual needs and incorporates child/youth and family voice/choice. Plans should be developed in the team process and incorporate the team's goals to support the child/youth and family.

**Rehabilitation** – Per SPA #10-016, rehabilitation means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

**Specialty Mental Health Services** – Per Title 9, Chapter 11, Section 1810.247, means:

- (a) Rehabilitative Mental Health Services, including:
- (1) Mental health services;
  - (2) Medication support services;
  - (3) Day treatment intensive;
  - (4) Day rehabilitation;
  - (5) Crisis intervention;
  - (6) Crisis stabilization;
  - (7) Adult residential treatment services;
  - (8) Crisis residential treatment services;
  - (9) Psychiatric health facility services;
- (b) Psychiatric Inpatient Hospital Services;
- (c) Targeted Case Management;
- (d) Psychiatrist Services;
- (e) Psychologist Services;
- (f) EPSDT Supplemental Specialty Mental Health Services; and
- (g) Psychiatric Nursing Facility Services.

**Therapeutic Foster Care (TFC)** – TFC will be added to this manual at a later date.

**Wraparound** – Wraparound is an intensive, individualized care planning and management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans and services that are effective and relevant to the child and family.

# APPENDIX B

## CORE PRACTICE MODEL

(From Appendix B of the Katie A. Settlement Agreement)

The Core Practice Model, which would be utilized by all agencies, or individuals who serve class members and their families, adheres to a prescribed set of family centered values and principles that are driven by a definable process. The Core Practice Model values and principles are summarized as follows:

- Services are needs-driven, strengths-based, and family-focused from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child/youth and family.
- Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.
- Family voice, choice, and preference are assured throughout the process.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.
- Services are culturally competent and respectful of the culture of the children/youth and their families.
- Services and supports are provided in the child/youth and family's community.
- Children/youth are first and foremost protected from abuse and neglect and maintained safely in their own homes.
- Children/youth have permanency and stability in their living situations.

In order to benefit from the full array of services they need, at whatever level appropriate and necessary to meet their needs, class members will be best served through five key practice components that are organized and delivered in the context of an overall child/youth and family plan. These five components include the following:

- **Engagement:** Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child/youth and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
- **Assessing:** Information gathering and assessing needs is the practice of gathering and evaluating information about the child/youth and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children/youth.
- **Service Planning and Implementation:** Service planning is the practice of tailoring supports and services unique to each child/youth and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child/youth, family, and caregivers.

- **Monitoring and Adapting:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
- **Transition:** The successful transition away from formal supports can occur when informal supports are in place and providing the support and activities needed to ensure long-time stability.

### **Child and Family Team (CFT):**

In those instances where intensive or complex needs are identified for the Katie A. Subclass, a formal CFT would be created to serve as the primary vehicle delivering services in accord with the Core Practice Model in order to bring significant individual team members together to help the family develop a plan of care that addresses their needs and strengths. The principle role of the CFT would be as follows:

- The CFT assembles as a group of caring individuals to work with and support the child/youth and family and, in addition to the various agency and provider staff involved in service delivery to the family, includes at a minimum a coordinator and a family support partner or family specialist for youth.
- Team facilitation can be done by a mental health provider, social worker, or probation officer. The coordinator maintains a committed team and is qualified with the necessary skills to bring resources to the table in support of the child/youth and family.
- An effective CFT continues the process of engagement with the family and/or caregivers about their strengths and needs, ensures services are well coordinated, and provides a process for transparent communication.



# APPENDIX C

## THE CHILD AND FAMILY TEAM (CFT)

The Work Group has also reached consensus that a subset of Katie A. class members need a more intensive approach and service delivery to address their array of needs and strengths, and that this subset would best be served through a formally organized *Child and Family Team*.

In those instances where intensive or complex needs are identified, a formal Child and Family Team would be created to serve as the primary vehicle delivering services in accord with the Core Practice Model in order to bring significant individual team members together to help the family develop a plan of care that addresses their needs and strengths. The principle role of the Child and Family Team would be as follows:

- The CFT assembles as a group of caring individuals to work with and support the child and family and, in addition to the various agency and provider staff involved in service delivery to the family, includes at a minimum a facilitator and a family support partner or family specialist for youth.
- Team facilitation can be done by a mental health provider, social worker, or probation officer. The facilitator maintains a committed team and is qualified with the necessary skills to bring resources to the table in support of the child and family.
- An effective CFT continues the process of engagement with the family and/or caregivers about their strengths and needs, ensures services are well coordinated, and provides a process for transparent communication.



# APPENDIX D

## ICC, IHBS AND TFC SERVICE REFERENCE CHART

### A. Intensive Care Coordination

<b>Definition</b>	<p>Intensive care coordination (ICC) is a targeted case management (TCM) service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of Katie A. Subclass. An ICC coordinator serves as the single point of accountability to:</p> <ul style="list-style-type: none"> <li>• Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the child/youth.</li> <li>• Facilitate a collaborative relationship among the child/youth, his/her family and involved child-serving systems</li> <li>• Support the parent/caregiver in meeting their child/youth's needs</li> <li>• Help establish the child and family team (CFT) and provide ongoing support</li> <li>• Organize and match care across providers and child serving systems to allow the child/youth to be served in his/her home community.</li> </ul>
<b>Service Components/Activities</b>	<p>While the key service components of ICC are similar to TCM, ICC differs in that it is integrated into the CFT process and it typically requires more active participation by the ICC provider in order to ensure that the needs of the child/youth in the Katie A. Subclass are appropriately and effectively met. As such the ICC service components include the following:</p> <p><u>Comprehensive Assessment and Periodic Reassessment</u></p> <p>These assessment activities are different from the clinical assessment to establish medical necessity for specialty mental health services but must align with the mental health client plan. Information gathering and assessing needs is the practice of gathering and evaluating information about the child/youth and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children/youth.</p>

**Service Components/  
Activities *continued***

Development and Periodic Revision of the Plan

Planning within the CPM is a dynamic and interactive process that addresses the goals and objectives necessary to assure that children/youth are safe, live in permanent loving families and achieve well-being. This process is built on an expectation that the planning process and resulting plans reflect the child/youth and family's own goals and preferences and that they have access to necessary services and resources that meet their needs.

The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (child welfare, education, juvenile probation, etc.) are integrated to comprehensively address the identified goals and objectives and that the activities of all parties involved with service to the child/youth and/or family are coordinated to support and ensure successful and enduring change.

Referral, Monitoring and Follow-Up Activities

Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The CFT is also responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan to address the changing needs of the child/youth and family in a timely manner, but not less than every 90 days. Intervention strategies should be monitored on a frequent basis so that modifications to the plan can be made based on results, incorporating approaches that work and refining those that do not.

Transition

When the child/youth has achieved the goals of his/her client plan, developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

<b>Provider Qualifications</b>	<p>Provider qualifications for ICC are the same as those allowed by DHCS for TCM services and as approved by the MHP. (See Appendix G which provides a description of providers eligible to provide services.)</p> <p>MHPs and providers in the SD2 provider master file currently certified to claim for procedure code T1017 will be automatically eligible to claim for ICC. With the next re-certification cycle the MHP must specifically indicate those providers who are eligible to provide ICC by using the Mode of Service 15 along with Service Function Code 07.</p>
<b>Service Authorization and Discharge</b>	<p>Service authorization should be consistent with the MHPs process for TCM.</p>
<b>Documentation Requirements</b>	<p>Documentation requirements should be consistent with the MHPs policies and procedures and the contract between DHCS and the MHP.</p>
<b>Service Limitations/ Lockouts</b>	<p>Service limitations and lockouts for ICC are equivalent to TCM service limitations and lockouts as described below:</p> <p>(42 CFR section 441.169) TCM does not include, and Federal Financial Participation (FFP) is not available when the TCM activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.2F).</p> <p>(42 CFR section 441.169) TCM does not include, and Federal Financial Participation (FFP) is not available when the TCM activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(9)(c)).</p> <p>FFP only is available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Act. (Sections 1902(a)(25) and 1905(c).</p> <p>For members of the target group who are transitioning to a community setting TCM services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days</p>

<b>Service Limitations/ Lockouts <i>continued</i></b>	<p>or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.</p> <p>ICC may be provided solely for the purpose of coordinating placement of the child/youth on discharge from the hospital, psychiatric health facility, group home or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.</p>
<b>Billing Code and Billing Requirements</b>	<p>ICC is claimed by using the standard unit of service for claiming and the TCM procedure code T1017 with the modifier HK.</p> <p>ICC will be reimbursed at the TCM rate.</p> <p>All other claiming and reimbursement requirements that apply to TCM apply to ICC.</p> <p>For more current information, please see the <a href="#">DHCS All County Information Notice</a> regarding ICC and IHBS billing.</p>

## B. Intensive Home Based Mental Health Services

<b>Definition</b>	<p>Intensive home-based mental health services (IHBS) are mental health rehabilitation services provided to members of the Katie A. Subclass. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family ability to help the child/youth successfully function in the home and community.</p>
<b>Service Components/Activities</b>	<p>Service activities may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant others to assist them in implementing the strategies;</li> <li>• Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;</li> <li>• Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT and service plans including but not limited to the plan and/or child welfare service plan;</li> <li>• Improvement of self-management of symptoms, including self-administration of medications as appropriate;</li> <li>• Education of the child/youth and/or their family or caregiver(s) about, and how to manage the child/youth's mental health disorder or symptoms;</li> <li>• Support of the development, maintenance and use of social networks including the use of natural and community resources;</li> <li>• Support to address behaviors that interfere with the achievement of a stable and permanent family life;</li> <li>• Support to address behaviors that interfere with seeking and maintaining a job;</li> <li>• Support to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community;</li> </ul>

<b>Service Components/ Activities <i>continue</i></b>	<ul style="list-style-type: none"> <li>• Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.</li> </ul>
<b>Provider Qualifications</b>	<p>IHBS are typically, but not always provided by paraprofessionals under clinical supervision. Peers including parent partners may provide IHBS.</p> <p>Provider qualifications for IHBS are the same as those allowed by DHCS for Mental Health Services and as approved by the MHP. (See Appendix G which provides a description of providers eligible to provide services.)</p> <p>All MHPs and providers in the SD2 provider master file currently certified to claim for procedure code H2015 will be automatically eligible to claim for IHBS. With the next re-certification, the MHP must specifically indicate those providers who are eligible to provide IHBS by using the Mode of Service 15 along with Service Function Code 57.</p>
<b>Service Authorization and Discharge</b>	Service authorization should be consistent with the MHPs process for authorizing Mental Health Services.
<b>Documentation Requirements</b>	Documentation requirements should be consistent with the MHPs policies and procedures and the contract between DHCS and the MHP.
<b>Service Limitations/ Lockouts</b>	<p>Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided.</p> <p>IHBS may not be provided to children/youth in Group Homes. IHBS can be provided to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits outside the Group Home setting.</p> <p>Certain services may be part of the child/youth's course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child/youth. These services include:</p> <ul style="list-style-type: none"> <li>• Day Treatment Rehabilitative or Day Treatment Intensive</li> <li>• Group Therapy</li> <li>• Therapeutic Behavioral Services (TBS)</li> <li>• Targeted Case Management (TCM)</li> </ul>



<b>Billing Code and Billing Requirements</b>	<p>In order to distinguish IHBS from non-Inpatient Specialty Mental Health services when claiming, IHBS uses a different procedure code and modifier (H2015 HK) and service function code (57). MHS are authorized and defined in California's existing Medicaid State Plan for Medi-Cal specialty mental health services.</p> <p>IHBS will be reimbursed at the same rates as Mental Health Services (MHS).</p>
--	--

## C. Therapeutic Foster Care Services

<b>Definition</b>	This service description will be added to the manual at a later date.
-------------------	---

# APPENDIX E

## SAMPLE PROGRESS NOTES

### Sample 1

Date: 1/10/13		Staff Service Duration: :40		Travel Duration :15		Documentation: :09	
Telephone Contact: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N		Other Staff Duration: :40		Travel Duration :15		Documentation: :00	
Procedure Code: T1017:HK							
Service: Intensive Care Coordination							
Location of Service: Client's Home							
<p><b>Goal:</b> John will increase replacement behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder to reduce client's kicking and punching siblings and peers from 5x per day to 1x per week.</p> <p>John reported no angry outbursts at school for the last 5 days. Has been playing basketball with peers after school. John also shared that he was invited to a classmate's birthday party on Saturday and is looking forward to going to the party.</p> <p>John's mother and grandmother reported his progress in self-regulation at home and school. With encouragement and prompting from maternal grandmother, John is able to complete his homework and has been taking care of his hygiene. He has been taking his prescribed medications without resistance from mother. Mother is pleased with client's behavioral improvement.</p> <p>Parent Partner informed team that Mrs. T continues to participate in school conferences and IEP meetings, which has helped mother better understand the context of John's behavior. Parent Partner also reported fewer altercations between client and mother because of improved communication styles between the two. ICC Coordinator led discussion regarding potential of IHBS worker decreasing amount of sessions at the home but continuing to reinforce anger management plan. John smiled at the idea of the IHBS worker coming less. When the ICC Coordinator prompted John to share why he was smiling, client stated "it makes me feel like I am getting better." Mother was supportive of the idea but asked if the IHBS worker could still come every week. The IHBS worker shared that she thought working on other ways to express feelings might be helpful to the John and his family.</p> <p>Parent Partner acknowledged mother's appropriate communication skills, discussed with mother importance of consistency in dealing with John's outbursts. Parent Partner will assist mother in developing a plan to support and recognize appropriate behavior and social interaction. IHBS worker will meet with John, reinforce his anger management plan and teach alternative ways in expressing feelings.</p> <p><b>Mrs. T. reported feeling much more confident in her own response when John is struggling and that she understands the importance of her response to John in helping him to stay calm.</b></p>							
_____ Signature & Discipline		_____ Date		_____ Co-signature & Discipline		_____ Date	

## Sample 2

Date: 1/13/13		Staff Service Duration: :40   Travel Duration :20   Documentation: :09	
Telephone Contact: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N		Other Staff Duration: :00   Travel Duration :00   Documentation: :00	
Procedure Code:   H2015:HK			
Service: Intensive Home Based Services			
Location of Service: Client's Home			
<p><u>Goal:</u> John will reduce aggressive behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder, including kicking and punching siblings, from 5x per day to 1x per week and will increase use of pro-social replacement behaviors.</p> <p>IHBS worker met with mother and aunt to identify situations and triggers at home that contribute to client's angry outbursts. Family reported that client has been throwing tantrums: kicking and punching his siblings; when they start playing and teasing each other it escalated and got out of hand.</p> <p>IHBS worker assessed home situation and assisted mother in identifying situations that lead to John's angry outbursts. IHBS worker and family discussed alternative ways to deal with John's frustration such as talking to client in a firm but calm tone of voice, and suggesting alternative options. IHBS worker also assisted mother in gaining a better understanding of client's behavior and need to recognize the behavior she wants to see at least once every 5 minutes from both boys, so that they know what they should do. Also, John agreed that he will take a short client time out when becoming angry. If he becomes violent towards self/family members, he will go to his room for a 15 minute period to calm himself. IHBS worker will continue to assist mother in identifying when the interaction is likely to become out of control so that she can intervene early as well as modeling appropriate responses to client's outbursts.</p>			
_____ Signature & Discipline	_____ Date	_____ Co-signature & Discipline	_____ Date

# APPENDIX F

## MEDICAL NECESSITY CRITERIA

### §1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

- (a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.
- (b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:
  - (1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:
    - (A) Pervasive Developmental Disorders, except Autistic Disorders
    - (B) Disruptive Behavior and Attention Deficit Disorders
    - (C) Feeding and Eating Disorders of Infancy and Early Childhood
    - (D) Elimination Disorders
    - (E) Other Disorders of Infancy, Childhood, or Adolescence
    - (F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
    - (G) Mood Disorders, except Mood Disorders due to a General Medical Condition
    - (H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
    - (I) Somatoform Disorders
    - (J) Factitious Disorders
    - (K) Dissociative Disorders
    - (L) Paraphilias
    - (M) Gender Identity Disorder
    - (N) Eating Disorders
    - (O) Impulse Control Disorders Not Elsewhere Classified
    - (P) Adjustment Disorders
    - (Q) Personality Disorders, excluding Antisocial Personality Disorder
    - (R) Medication-Induced Movement Disorders related to other included diagnoses.
  - (2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:
    - (A) A significant impairment in an important area of life functioning.
    - (B) A reasonable probability of significant deterioration in an important area of life functioning.
    - (C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

### **§1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.**

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshe.





# APPENDIX G

## PROVIDERS ELIGIBLE TO DELIVER ICC AND IHBS

	May direct services by either <ul style="list-style-type: none"> <li>• Signature on Client Plan</li> <li>• Supervision of staff providing service</li> </ul>	May provide services and/or be client's care coordinator	May provide: <ul style="list-style-type: none"> <li>• Mental Status Examination</li> <li>• Diagnostic Information</li> </ul>
Physician	YES	YES	YES
Psychologist	YES	YES	YES
LCSW	YES	YES	YES
MFT	YES	YES	YES
Intern, CSW/MFT (post Master's degree and registered/waivered) Intern, Psychologist (post PhD and DMH waiver of licensure)	YES	YES	YES
RN with Master's degree in Psychiatric/Mental Health Nursing	YES	YES	YES
RN	YES	YES	NO
LVN/LPT	NO	YES	NO
Trainee for CSW, MFT, Clinical Psychology (post BA/BS but pre Master's/PhD degree)+	NO	YES	YES+
MHRS	NO	YES	NO
Staff with MH related BA/BS, or 2 years' experience in Mental Health	NO	YES	NO
Staff without either BA/BS, or 2 years' experience in Mental Health+	NO	YES	NO

+DOCUMENTATION MUST BE CO-SIGNED BY AN LPHA WITHIN THEIR SCOPE OF PRACTICE.

## PROVIDERS ELIGIBLE TO DELIVER ICC AND IHBS

	Physician	Licensed or Waivered Psychologist (post PhD)	Licensed or Registered (post MA/MS) LCSW or LMFT	Registered Nurse with Master's in Mental Health Nursing	Mental Health Nurse Practitioner
Assessment: History & Data collection	YES	YES	YES	YES	YES
Assessment: MSE & Diagnosis	YES	YES	YES	YES	YES
Develop Individual Client Plan	YES	YES	YES	YES	YES
Approve Individual Client Plan	YES	YES	YES	YES	YES
Provide ICC	YES	YES	YES	YES	YES
Provide IHBS	YES	YES	YES	YES	YES

	Registered Nurse (without Master's in MH Nursing)	Licensed Vocational Nurse or Licensed Psychiatric Technician	Trainee for LCSW, MFCC, PhD (graduate student)	Mental Health Rehabilitation Specialist (AA + 6 yrs; BA + 4 yrs; MA + 2 yrs experience)	Staff without qualifying experience and education for other categories (specifics may vary by county)
Assessment: History & Data collection	YES	YES	YES+	YES	YES+
Assessment: MSE & Diagnosis	NO	NO	YES+	NO	NO
Develop Individual Client Plan	YES	YES	YES+	YES+	YES+
Approve Individual Client Plan	YES	YES	NO	NO	NO
Provide ICC	YES	YES	YES+	YES	YES+
Provide IHBS	YES	YES	YES+	YES	YES+

**+DOCUMENTATION MUST BE CO-SIGNED BY AN LPHA WITHIN THEIR SCOPE OF PRACTICE.**

# APPENDIX H

## NON-REIMBURSABLE ACTIVITIES

### CCR, Title 9, Chapter 11, § 1840.312. Non-Reimbursable Services - General.

The following services are not eligible for FFP:

- (a) Academic educational services.
- (b) Vocational services that have as a purpose actual work or work training.
- (c) Recreation.
- (d) Socialization is not reimbursable if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.
- (e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.
- (f) Medi-Cal program benefits that are excluded from coverage by the MHP as described in Section 1810.355.
- (g) Specialty mental health services covered by this Article provided during the time a beneficiary 21 years of age through 64 years of age resides in any institution for mental diseases, unless:
  - (1) The beneficiary was receiving, prior to his/her twenty-first birthday, services in an institution for mental diseases and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier; and
  - (2) The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which FFP may be available include but are not limited to acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services.
- (h) Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through 441.156. Facilities at which FFP may be available include acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.
- (i) The restrictions in Subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.
- (j) Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5 to the extent that they are provided to beneficiaries whose Medi-Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services.
- (k) The MHP may not claim FFP for specialty mental health services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

# APPENDIX I

## KATIE A. SETTLEMENT BACKGROUND

On July 18, 2002, a lawsuit entitled *Katie A. et al. v. Bonta et al.* was filed seeking declaratory and injunctive relief on behalf of a class of children in California who (1) are in foster care or are at imminent risk of foster care placement, (2) have a mental illness or condition that has been documented or—if an assessment had been conducted—would have been documented, and (3) need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

In December, 2011, a settlement agreement was reached in the case. As part of this agreement, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) agreed to perform a number of actions, including the development and distribution of this Documentation Manual, with the following objectives:

- To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery and transition into a coherent and all-inclusive approach, hereinafter referred to as the Core Practice Model or CPM, as defined in Chapter 2.

- To address the need for subclass members with more intensive needs to receive medically necessary mental health services that include Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC). (The descriptions for IHBS and ICC are described fully in Chapter 3, *supra*)
- To clarify and provide guidance on the coverage and documentation requirements under Medi-Cal of IHBS and ICC so that counties and providers can understand these requirements and consistently apply them.

The Katie A. settlement further provides that:

- CDSS and DHCS, in consultation with the joint management taskforce, will develop and endorse practice tools, training curriculum, practice improvement protocols, and quality control systems to support the shared CPM, in order to support service integration and/or coordination of mental health services for class members.
- CDSS and DHCS will develop cross-system training curriculum and educational materials for child welfare and mental health staff.

# ACKNOWLEDGMENTS

The Department of Health Care Services and the California Department of Social Services would like to thank the following agencies who assisted in the development of the Medi-Cal Manual for ICC, IHBS and TFC by contributing their valuable time, experience, knowledge, and dedication to children/youth and families.

## **Members of the Documentation Manual Subgroup**

**California Mental Health Directors Association**

**California Welfare Directors Association**

**Counties**

**Parent Partners**

**Providers**